Health Data: A Vital Resource for Health System Performance Improvement

Recommendations of the Health Data Workgroup

to

Advisory Council on Health Systems Development

January 28, 2011

This Presentation

- Overview of the Workgroup's charge, membership and process.
- Recommendations
- Background: key problems and issues

Key Principles and Recommendations

Focus: the availability and use of data to understand the cost and quality performance of Maine's health system.

Question: What is/are the essential functionality and components of a data system that will support decision making by consumers, clinicians, health systems/ACOs, health plans, and policy makers.

Principles

- Timeliness of information is paramount for clinical and health system/ACO decision making;
- Supporting clinical data needs a first priority.
- Both “centralized” (e.g. all-payer database) and “de-centralized” systems (e.g. Beacon) will be needed.
- Administrative claims submissions will continue
- Linking clinical and administrative data critical.
- Link existing databases/systems rather than create new ones.
- Build analytic capacity at all levels of the system.
- Flexibility will be needed as we learn what we need to know.

***Issue**: Maine needs a data warehousing capability and systems that can link clinical and administrative data and make them accessible on a timely basis for clinical, policy, research and other uses.*

Recommendation #1:

The Office of the State Coordinator, Health Information Technology, the Maine Quality Forum, and the Maine Health Data Organization/Data Processing Center should work with stakeholders to develop a feasibility analysis and business plan for a permanent data warehousing capability/system.

***Issue**: Providers, clinicians, purchasers and others will need to be able to link data across systems for individuals and providers over time for the purposes of identifying patients across providers (and time), attribute patients to providers, and physicians to practices. The challenges of establishing master patient and provider indexes are major impediments.*

Recommendation #2:

A Subcommittee of the Health Data Workgroup should evaluate barriers to data linkage, options for facilitating linkage, and make recommendations to the MHDO, DPC, Legislature (and/or others) to enable data linkage within a secure privacy framework.

***Issue**: Maine has an abundance of population health data (e.g. BRFSS) that are not accessible to communities, providers and others for whom information about the health of communities and populations could inform planning and management of new delivery system models (e.g. medical homes, Accountable Care Organizations), and clinical and policy decision making. The lack of information on ethnic and racial minorities is also of particular concern.*

Recommendation #3:

A subcommittee of the Workgroup should define what "minimum data" are needed for population health data that could be used by providers, the public health system, the ACHSD and others to monitor and improve the health of communities and populations.

***Issue**: The ability to use the data that we have in Maine and that we envision for the future requires that government, healthcare providers, and others have data analytic capacity, including data systems analysis, epidemiological, and health economics and services capacity. There is a sense that Maine is under resourced in this regard by virtue of the fact that we lack sufficient undergraduate and graduate training capacity.*

Recommendation #4:

The Maine CDC and MaineCare should collaborate with stakeholders and the state's universities to assess current and future workforce needs in this field and options for building Maine's .

***Issue**: The so-called "cost drivers" study highlighted that ACHSD, health systems, purchasers and others need regular health system performance monitoring data to track trends in (1) health status and other population health indicators, (2) health spending, costs, and utilization relative to specific benchmarks, (3) health access and disparities, and (4) patient safety and quality. Although the Commonwealth Fund, America's Health Rankings, the County Health Rankings, and other reports provide important and useful data on key performance indicators, additional indicators and analysis focused on Maine's health care cost issues is needed.*

Recommendation #5:

ACHSD should prepare a template for and produce a statewide health system performance report every 3 years (perhaps on a staged basis with different sections being done each year) with funding from multiple sources (e.g. philanthropy, purchasers, government).

Health Data Workgroup: Background and Process

Charge from the State Health Plan

Goal VII.4: Develop a roadmap for continuing to build Maine's health data, analysis, and research infrastructure to support health care payment, delivery system reform, workforce development, and health system performance monitoring to improve health status. (Goal VII.4)

Tasks Assigned to the ACHSD in the 2010 – 2012 State Health Plan

- Convene a workgroup containing interested stakeholders
- Inventory and assess current systems and sources
- Develop a vision for Maine's health data and data use infrastructure
- Identify gaps and barriers
- Develop a roadmap of policy and other action steps to move Maine toward the health data and data use infrastructure that will be needed[3]

Health Data Work Group

- Convened in September 2010 for 4 meetings by State Coordinator for HIT
- Chaired by former State Rep., Anne Perry
- Broad/diverse membership: ACHSD, public and private data and research organizations (e.g. MHDO, Onpoint Health Data), universities, public and private purchasers (e.g. MaineCare, MHMC), health care providers, public health.

Approach

- Four meetings structured around presentations from the different perspectives of those involved with health data, from providers and data producers.
- These presentations highlighted key ***issues*** and ***principles*** for strengthening Maine's health data systems.
- Recommendations are based on these issues and principles.

Next Steps

- Final report, incorporating today's input from ACHSD
- Prioritize implementation of recommendations based on available resources

LD 1467 and Resolve

Original LD 1467

An Act To Improve Timely Access to Health Care Data

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this bill establishes the Health Information Database Advisory Group to advise the Maine Health Data Processing Center and the Maine Health Data Organization on the maintenance and updating of the all-payor and all-setting health care database system; and

Whereas, this bill requires the Health Information Database Advisory Group to submit its recommendations no later than January 1, 2012; and

Whereas, immediate enactment of this bill is necessary to give the Health Information Database Advisory Group adequate time to fulfill its duties; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 10 MRSA §682-A is enacted to read:

§ 682-A. Health information database; access to data

1. Database. Under the direction of the Health Information Database Advisory Group, established in subsection 2, the center, established in section 681, in conjunction with the Maine Health Data Organization, established in Title 22, chapter 1683, and Onpoint Health Data shall maintain and update the all-payor and all-setting health care database system to improve timely access to data in accordance with the following.

A. An independent manager of the center must be appointed to manage the processing of the database in a neutral manner. Only one system for processing the database and establishing central data files may be supported.

B. All current requirements for claims submissions must be maintained, except that the requirement that payors submit dental claims and the requirement that small commercial payors covering 50 to 499 lives submit claims must be evaluated.

C. The MaineCare and Medicare programs, to the extent permitted under federal law, shall submit claims data through the same processing system and in the same manner as commercial payors.

D. Health plans must be required to submit provider contact information, including address and physical location, and expanded personal health care information related to claims data using 2-way encryption technology or other technology to protect the confidentiality of the information.

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E. New performance standards must be implemented to improve the timeliness of the data, including changes to filing requirements, standardized reporting and the development of a database repository. If performance standards recommended by the Health Information Database Advisory Group established in subsection 2 are not met, the Health Information Database Advisory Group is authorized through a competitive bidding process to contract with a qualified independent entity for services that meet the performance standards established in accordance with this paragraph.

F. Standards for reporting from the database must be updated with the input of stakeholders, including payors, providers and organizations seeking access to the database.

G. The assessments charged to payors and providers submitting claims data must be reduced to reflect updates made in accordance with this section.

H. User licenses must be established to provide access to the database by qualified licensees.

The Maine Health Data Organization may adopt or amend its rules as necessary to implement the requirements of this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Resolve, To Evaluate the All-payor Claims Database System for the State

Sec. 1 Creation of working group. Resolved: That the Department of Health and Human Services, referred to in this resolve as "the department," shall establish and convene a working group to evaluate options and actions available to improve the availability of and access to health care data and to examine the all#payor claims database system in the State; and be it further

Sec. 2 Membership. Resolved: That the Commissioner of Health and Human Services shall invite 17 persons to participate in the working group, as follows:

1. Two representatives of health insurance carriers;

2. Two representatives of health care providers, one member representing hospitals and one member representing physicians;

3. Two representatives of employers, one member representing a statewide health management coalition and one member representing a statewide chamber of commerce;

4. One representative of consumers;

5. One expert in both state and federal privacy laws;

6. One representative of the Maine Health Data Organization;

7. One representative of the Maine Health Data Processing Center;

8. One representative of Onpoint Health Data;

9. One representative of the Department of Administrative and Financial Services, Office of Information Technology;

10. One representative of HealthInfoNet;

11. One representative of the MaineCare program within the department;

12. One representative of the federal Medicare program;

13. One representative of the Office of the Attorney General; and

14. One representative of the Maine Quality Forum; and be it further

Sec. 3 Cochairs. Resolved: That the members of the working group shall select 2 of the members to serve as cochairs; and be it further

Sec. 4 Evaluation. Resolved: That the working group shall consider changes to the State's all-payor claims database system to improve the availability of and access to health care data by:

1. Reviewing the current structures of and relationships among the Maine Health Data Organization, the Maine Health Data Processing Center and Onpoint Health Data in order to evaluate the timeliness and effectiveness of the data received;

2. Reviewing the current purposes and uses of the data and limitations on access to the data and
considering additional uses for the data and changes that might be necessary to achieve and facilitate
additional uses;
3. Considering federal and state privacy and security laws regarding the use and release of protected
health information, including policy and technical changes needed to allow increased access to protected
health information and the feasibility of those changes; and
4. Considering the availability of the data, the most appropriate sources of the data and the cost of
providing the data; and be it further
Sec. 5 Funding and staffing. Resolved: That the department shall provide staffing assistance
to the working group through contracted professional services and shall seek outside nonstate funding
to support staffing services and administrative costs for the working group. If adequate funding is not
obtained, the working group may not convene or incur any expenses; and be it further
Sec. 6 Report. Resolved: That, by January 31, 2012, the department shall report the recommendations based on the findings and conclusions, determined by vote, of the working group, along
with any recommended implementing legislation, to the Joint Standing Committee on Health and Human
Services

DHHS Resolve Workplan

DRAFT OUTLINE
LD 1467 Resolve Project Plan

ID	Task Name	Duration	Start	Finish	Milestone	% Complete	Domain
1	Emerging Healthcare Delivery Models Data-Info Needs	140 days?	Tue 10/4/11	Mon 4/16/12	No	0%	Research
21	Quality Measurement and Data Needed	60 days?	Wed 11/2/11	Tue 1/24/12	Yes	0%	Research
46	Assess State Data Systems	129 days?	Tue 10/4/11	Fri 3/30/12	Yes	0%	Assessment
67	Identify Gaps in Measurement from Data	90 days	Wed 11/2/11	Tue 3/6/12	Yes	0%	Assessment
80	Merging of Clinical and Claims Data	249 days?	Mon 7/4/11	Thu 6/14/12	No	0%	Assessment
86	Benchmarking Other States	66 days?	Wed 11/2/11	Wed 2/1/12	No	0%	Research
91	Stakeholder Input	118 days?	Tue 10/4/11	Thu 3/15/12	No	0%	Stakeholder
113	Protected Health Information	54 days?	Thu 12/15/11	Tue 2/28/12	Yes	0%	PHI
119	Future Vision and Roadmap	90 days?	Mon 9/3/12	Fri 1/4/13	Yes	0%	Recommendations
126	HHS Committee Presentations	242 days?	Wed 2/29/12	Thu 1/31/13	Yes	0%	Reports